State of Delaware Vision Plan Comparison Chart
(Effective July 1, 2021)

Please note: The specific premiums (rates) referenced in this document apply to State of Delaware employees. Flex credits offered to school district or charter school employees to reduce their employee premiums for vision benefits are not reflected in this information. Please see your HR/Benefits Office for information about your flex credits.

Plan Options	EyeMed Low Vision Plan		EyeMed High Vision Plan	
Network	Insight		Insight	
Coverage Options/ Premiums (Rates)	**Total Monthly Premium (Rate)**	**Bi-Weekly Premium (Rate)**	**Total Monthly Premium (Rate)**	**Bi-Weekly Premium (Rate)**
Employee	$6.48	$3.24	$13.06	$6.53
Employee & Spouse	$10.24	$5.12	$20.64	$10.32
Employee & Child(ren)	$10.42	$5.21	$21.04	$10.52
Family	$16.84	$8.42	$33.94	$16.97
Plan Feature	**In-Network Member Copay**	**Out-of-Network Reimbursement ("Up to" amount noted)**	**In-Network Member Copay**	**Out-of-Network Reimbursement ("Up to" amount noted)**
Exam	$10	$30	$5	$30
Retinal Imaging	Up to $39	N/A	$0	N/A
Frame	$0 copay; $160 allowance, 20% off balance over $160	$45	$0 copay, $210 allowance, 20% off balance over $210	$105
Standard Plastic Lenses - Single Vision or Bifocal or Trifocal	$20	$25 Single $40 Bifocal $55 Trifocal	$10	$25 Single $40 Bifocal $55 Trifocal
Standard Progressive Lenses	$85	$40	$10	$40
Premium Progressive - Tier 1, 2, 3	Tier 1 $105 Tier 2 $115 Tier 3 $130	$40	Tier 1 $95 Tier 2 $105 Tier 3 $120	$40
Premium Progressive – Tier 4	$85 copay; 80% of charge less $120 allowance	$40	$75 copay; 80% of charge less $120 allowance	$40
Lens Option - Anti Reflective Coating - Standard	$45	N/A	$0	$5
Lens Option - Standard Polycarbonate - Adult	$40	N/A	$0	$5
Lens Option - Standard Polycarbonate - Kids under 19	$0	$5	$0	$5
Contact Lenses *(Conventional)*	$0 copay, $160 allowance, 15% off balance over $160	$105	$0 copay, $210 allowance, 15% off balance over $210	$170
Contact Lenses *(Disposable)*	$0 copay, plus 100% of balance over $160	$105	$0 copay, plus 100% of balance over $210	$170
	Frequency		**Frequency**	
Exam	Once per plan year		Once per plan year	
Frame	Once per plan year		Once per plan year	
Lenses or Contact Lenses	Once per plan year		Once per plan year	
Medical Follow-Up Exam for Diabetic Vision Care	Once every 6 months (up to twice per plan year)		Once every 6 months (up to twice per plan year)	

Important Note: For more information about all the benefits offered through the State's vision plan, including the plan limitation and exclusions, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.